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'Bad' mums tell the 'untellable': narrative practices and agency in online stories about postnatal depression on Mumsnet

1. Introduction

Web 2.0 technologies have become the most popular resources when it comes to making sense of illness. 'Going on the Internet' to seek information about one's condition is now a routine practice (Ziebland and Wyke 2012). Patient forums have been shown to be particularly beneficial; hearing illness stories of others can reduce one's sense of isolation, offer support and provide information that patients utilise to make decisions and access better treatment options. Research exploring aspects of health and illness communication on digital channels continuously highlights the transformative and empowering effects that telling and sharing stories and coping strategies online has on patients and carers (Ziebland and Wyke 2012, Naslund et al. 2015, Newhouse et al. 2017). Yet, most research in this area has been concerned with contents and measurable impacts of online health communication and we still know little about the practices and processes that contribute to such effects. This is important to explore because even if we know that peer-to-peer online communication is transformative, we need to understand *how* such transformations happen and how the digital affords therapeutic and transformative effects (Ley 2007, Drentea and Moren-Cross 2005, Van Doorn 2011).

Drawing on previous applied linguistic research on health communication in digital environments (Hamilton 1998, Jones 2010, Page 2012, Harvey 2012, Anesa and Fage-Butler 2015, Koteyko, and Hunt 2016), this paper argues that a closer attention to the language and other linguistic resources which people use in sharing their illness stories online can contribute to a better understanding of the practices and processes of health transformations. Language is a gamut of tools which people use to think, act, create and maintain relationships (Jones 2013). Therefore studying in detail the kinds of linguistic 'tools' that people utilise to tell their stories online and engage with others can shed light on *what* people do when they talk about illness online and *how* they do it.

This paper attempts to contribute to this understanding by examining the ways in which participants in an online discussion forum disclose postnatal depression (PND) and engage in peer-to-peer interactions about this condition. PND presents an important case to study; it is a

highly stigmatised condition, which in the UK affects 10-15% mothers (NHS 2016) with suicide due to PND being the leading cause of maternal death (Oates 2003). Despite the gravity of the problem, women rarely seek help and most suffer in silence because of the social stigma surrounding PND. As with any mental health issue, the opportunity to talk about the condition is essential to diagnosis and treatment. Because so many are reluctant to disclose it, little is known about the ways in which PND is 'talked about' and subjectively experienced. In the UK, the issue is compounded by the recent public funding cuts to maternal and child services, especially health visitors who are often the first point of contact and trained to spot signs of PND. Furthermore, the social context of late modernity and increased mobility seem to have impact on the support structures for pregnant women and mothers. Whereas previous generations relied on information and support from parents and relatives, many women live now far away from their families. There is less time and fewer opportunities to engage with offline friends and family members in general (Ley 2007). Given the stigma and diminishing offline support, the digital medium has emerged as a channel offering new possibilities for women to tell their pregnancy and motherhood stories including PND (Kantrowitz-Gordon 2013, Drentea and Moren-Cross 2005). What kind of PND stories they tell online and which linguistic and other resources they harness to make sense of this illness is the main concern of this paper.

Studying the kind of stories shared by people belonging to stigmatised groups is relevant for at least two reasons. First, narratives are important tools for social groups to establish bonds and legitimacy (Polanyi 1985; Jones 2016). They give people a voice and "textual authority" to make their concerns legitimate and hearable in society (Jones 2016: 320). Conventionalised narrative genres are especially powerful in this respect since they provide a kind of templates that communities use to make sense of personal experience (Bamberg 2007). Second, narratives are important verbal resources for the formation and display of identity in that they give people the opportunity to tell who they were, who they are and who they would like to be (Schiffrin 1996; Wortham 2000). However, rather than just being descriptions of a unified pre-existing self (Wortham 2000), research in interactional sociolinguistics has shown that storytellers project different aspects of their identity depending on the context and the audience, and exploit different discursive and linguistic devices to do so (e.g. Schiffrin 1996; Jones 2010, 2016). When telling a story, people may select a particular kind of narrative and thus a particular position that the narrative makes available. For example, in choosing the narrative genre of exemplum, a storyteller speaks

from the position of a 'teacher' (Jones 2016). Speaking from the position of a teacher requires the existence of the position of a 'student' who accepts to be spoken to by a teacher. A position can therefore be understood as an interactional matrix through which people locate themselves and others interactionally in the stories that they tell – a discursive process which Davies and Harrè (1990) call positioning. In this sense, positions say as much about the teller(s) as about the listener(s) and the relationship between the two.

Linguistic research concerned with positioning stresses three aspects. First, positions are never fully "properties of individuals alone" (Schiffrin 1996: 196). Rather they are defined by larger cultural scripts or big D Discourses (Gee 1999) and are sets of social obligations and expectations that 'prescribe' what can be said and what forms of behaviour can be enacted within a particular position. Second, positions can be foregrounded not only through the use of larger narratives but also through the choice of 'smaller' linguistic and paralinguistic devices, for example, when the teller uses reported speech to display an agentive self (Schiffrin 1996; Hamilton 1998). The larger narrative structures, content and 'smaller' linguistic devices all work together to emphasise or background particular positions and therefore particular aspects of identity. Third, positions are never fixed pre-discursive entities "ready to be taken off the shelf and to be reproduced" (De Fina and Georgakopoulou 2012: 163). Research in interactional sociolinguistics has demonstrated that people agently select, resist or shift positions in interactions and in so doing, create tensions between the larger cultural scripts and their own stories (Jones 2010). It is in these tensions that transformations of positions and thus identity can happen.

Drawing on the notions of narrative, small story and positioning, this study examines stories produced online by women with PND. The data under study is an example of digital storytelling and involves polylogue stories generated in online peer to peer interactions. While the stories vary in length, most are just short fragments retelling recent or still unfolding events. Hence, they largely depart from the prototypical narrative (Labov and Waletzky 1997) and are examples of what Georgakopoulou (2008: 601) calls *small stories*. This study is particularly interested in what kind of narrative structures and linguistic resources women with PND draw on to tell their stories online, what positions these kinds of stories make available and to what extent these are appropriated, resisted or shifted. This requires essentially a scrutiny of the interactions as they unfold examining in detail the narratives of original (or first) post posted in a discussion thread and responses to those (Giles 2016).

At the micro level, the analysis reveals that despite the *small* character of the online stories, the forum users draw on two *big* canonical narratives, that is, *confession* and *exemplum*. These two canonical narratives and the positions that they make available are evoked through the choice of specific linguistic devices and offer women a framework to talk about this stigmatised condition. However, the two genres serve different purposes. Whereas confessions are a 'way in' to disclose PND, the exempla that follow serve as tools of alignment and validation helping women to narratively redefine and repair the 'spoiled' identity (Goffman 1963). At the macro-level, the analysis highlights tensions that exist between hegemonic discourses about motherhood and personal PND stories in which women appropriate and re-work these discourses to break silence and exercise agency. In so doing, this study contributes to a better understanding of narrative practices underlying online peer to peer interactions about stigmatised conditions and show how these practices work together to produce transformative effects of online trouble telling and sharing.

2. Research perspectives on postnatal depression

PND belongs to the category of postpartum mood disorders and is a type of depression which can occur within one year of childbirth (Evans et al. 2012). Symptoms may involve low mood, lack of energy, loss of interest in the world, difficulties in bonding with the baby, suicidal thoughts and self-harm. Although research literature considers history of mental health issues, stressful events and low social support to be strong predictors of PND, the aetiology remains unknown (Evans et al. 2012).

As with many mental health conditions, research on PND has been preoccupied with clinical aspects, mostly label-based descriptions, symptoms and pharmacological management equating PND with a physical condition (Kokanovic et al. 2013). Some argue that such an approach reflects the dominant biomedical model that underlies much of the current thinking about health and illness reducing psychological illness to neurochemical disorder of the brain and leaving out the consequential social, cultural and economic realities (Lafrance 2007; Rose 2007).

The criticism of the biomedical model has generated considerable research interest in discourses around depression, including PND. Most of this research has focused on medical perspectives revealing the ways in which medics and media promote a somatic self, for example, by appealing to women's sense of agency and encouraging them to draw on

pharmaceutical expertise (Gattuso et al. 2005; Fullagar 2008). Yet, we know little about the extent to which such practices are adopted by patients who suffer from depression.

This is true of PND in that we know little about the 'messy' realities of how women experience the condition and what kind of discourses and practices they draw on when trying to come to terms with PND. The few accounts that exist point to complex ways in which women try to make sense of PND. Edhborg et al. (2005) identify identity loss as the dominant theme in interviews with women who suffer from PND. When trying to understand the condition, most women draw on the highly normative discourse of intensive mothering (Hays 1998), which makes only one subject position available that of a caring and happy mother. Because their experience 'deviates' so much from that 'model', they see themselves as failures and bad mothers.

Social support is key in helping women with PND. Yet, lack of knowledge about available services and the stigma attached to PND prevent women from considering face to face support (Kim et al. 2010). Instead, many take to the Internet to talk about PND. Online peer to peer support seems to afford new possibilities to disclose stigmatised conditions. Specifically, anonymity, informality, freedom of expression and 24/7 access have been identified as factors encouraging disclosure of a trouble online. Evans et al. (2012) explores the benefits of online support groups for women with PND and shows how online discussions offer emotional and informational support. Using content-analytical techniques, Kantrowitz-Gordon (2013) examines online disclosures of PND. She observes that women draw on biomedical discourse to position PND as a legitimate illness and distance themselves from the condition. This follows from the theorising that a biomedical aetiology constitutes somehow a 'real' illness, whereas a lack of bodily signs positions a condition as not 'real' and 'just in the mind' (Lafrance 2007). Although the use of biomedical model legitimises PND in biomedical terms, Kantrowitz-Gordon (2013) argues that the adoption of this model perpetuates the one-dimensional view of depression as a biological condition independent of cultural and social factors.

Studies concerned with the subjective experience of PND online and offline show how women draw on different explanatory models (biomedical, moral) to understand the illness and re-define their situation. However, how such redefinitions happen and what kind of linguistic and other semiotic resources women harness to repair 'spoiled' identity (Goffman 1963) is still little understood.

Discourse-analytical research on online health communication conducted in applied linguistics can offer here useful perspectives. It foregrounds the significance of language in use, specifically how people appropriate discourse and other semiotic resources to position themselves and others to accomplish their goals and negotiate identities (Jones 2013). In one of the first studies, Hamilton (1998) shows how patients who underwent a bone marrow transplant strategically deploy reported speech to construct agentive selves as survivors and not as victims of the disease. Jones (2010) examines the ways in which gay men exploit the digital medium to manage social identities in the context of discussions about safe sex. He shows that lay constructions of notions such as 'risk' or 'safe sex' are less dependent on authoritative discourses and more on the negotiations of meanings in online interactions. Investigating cancer blogs produced by women and men, Page (2012) demonstrates how in contrast to men, women use evaluative anecdotes to build a network of social support. Turning to social networking sites (SNS), Koteyko and Hunt (2016) illustrate how members of a Facebook diabetes group use creative language and visual resources to cope with the mundane management of a chronic illness. The authors note that because of non-anonymity and context collapse, SNSs discourage users to express negative emotions or challenge the medical status quo; the participants seem to stick to one dominant voice around positive and unproblematic storylines, while anything controversial is avoided. Although largely monomodal with no opportunities to use other semiotic resources such as images or videos, online discussion forums might be better sources of authentic and multiple voices because in anonymous environments participants feel less pressurised to attend to 'face' needs (Seale 2011). Hence, anonymous posts are more likely to present 'unedited' voices allowing richer insights into how people 'do' health in everyday life. For this reason, this study investigates anonymous online posts only.

3. Data, Methodology and Ethics

This study is based on an analysis of online discussions about PND posted on the largest parenting website in the UK Mumsnet. The website includes a discussion forum *Talk*, which attracts over 6 million unique visitors per month. Although it is difficult to say precisely who the members of Mumsnet are, a census conducted by Mumsnet in 2009 suggests that they are overwhelmingly middle-class women aged 30 to 40, many of whom have a university degree

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and are professional working mothers (Mumsnet 2009). These are important demographic and contextual factors to consider when interpreting the results (Giles 2016).

The data for the analysis was sourced from *Talk*, which is organised around general themes pertaining to parenting, health, work etc. *Talk* is a public forum that can be browsed by members and non-members, but only registered member can post. The forum was searched for instances of threads containing the terms 'postnatal depression' or 'pnd'. The search yielded more than 200 results but many of the threads had just the word 'depression' in the title. Hence, all the results were scrutinised and only those that included references to 'postnatal depression' or 'pnd' in the title and had more than three responses were considered for analysis. The selection resulted in 18 threads with 347 posts in total.

The terms and conditions of Mumsnet stipulate that *Talk* is a public space and users are made aware that anyone can view their posts. People use pseudonyms to post messages and their identity is protected. There is a great deal of discussion about ethical issues related to the use of contents from public discussion forums. Some argue that informed consent from the participants should be obtained in any case, whereas others claim that by posting anonymously participants automatically give their consent (Roberts 2015). No agreement has been yet reached. Following procedures adopted in previous research using posts from Mumsnet (e.g. Pedersen 2016), consent was not sought from the participants because the material used was not directly elicited from them and only obtained after it was spontaneously generated. Yet, the terms and conditions of Mumsnet state that all contents published on its site are the sole property of Mumsnet and reproduction of any parts without approval is prohibited. Consent was therefore sought from Musmnet to use the *Talk* data for the purpose of this research and approval was granted. The approval stated that usernames or any other potentially identifying details must be removed to protect posters' anonymity and this procedure was adopted throughout.

Drawing on previous linguistic research on online health communication (Jones 2010, Hunt and Koteyko 2016) and specifically digital story telling (Page 2012), first posts and responses to those were scrutinised to identify the existence of narrative structures and the lexico-grammatical resources that index these structures. A clear pattern of confession followed by exempla emerged and these two structures were investigated in more depth by analysing their form, functions and the kind of positions that they enabled in the studied context.

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4. Results and Discussion

Table 1 shows the titles of OPs, the number of posts in each thread and the number of unique participants. The acronym AIBU used in the first two threads stands for 'Am I being unreasonable' and normally topics discussed in this category are dilemmas ranging from serious matters to tongue-in-cheek questions. AIBU threads are the most popular and interactive on Mumsnet.

Examination of the titles, contents and the dominant narrative structure in all posts in each thread has revealed the following pattern: Almost all of the threads start with a confession followed by exempla interspersed with thank-you messages and recounts produced by the original poster (OP). Appendix 1 demonstrates an indicative example of this pattern. The analysis section begins therefore with discussing the narrative practice of confession; subsequently the form and functions of exempla are analysed. This is followed by an examination of the last responses produced by the OP to see effects that the exchanges had on them.

Table 1: Thread titles and number of posts, and participants in each thread

	Title	Post	Participants
1.	AIBU to ask for positive pnd outcome stories?	44	25
2.	AIBU to not take antidepressants for postnatal depression?	35	26
3.	postnatal depression/anxiety positive recovery stories please	35	12
4.	started on sertraline for pnd - hand holding needed	33	11
5.	Postnatal depression vs "not coping"	29	7
6.	Embarrassed about postnatal depression	24	13
7.	Have i got post natal depression?	23	9
8.	Post Natal Depression - long road back	21	3
9.	To all those feeling hopeless...it does get better, I promise.	16	11
10.	Post Natal Depression 2nd time round?	15	9
11.	Do I have postnatal depression or is this normal feeling for a new mum of twins?	14	9
12.	Suffering with postnatal depression and extreme anxiety	14	10
13.	PND showing as anxiety and CBT	10	8
14.	Postnatal depression- 4 years on	9	4
15.	Postnatal depression	9	7
16.	Postnatal depression 6 months post partum	8	5
17.	Late onset Postnatal yet again	4	2
18.	Postnatal depression	4	2

4.1 Opening lines: small confessions

Most of the opening posts in the data are personal disclosures of PND. While the length and degree of detail included in the disclosures vary, what they have in common is their confessional character. In fact, most of them are forms of *small confessions* in which often for the first time the OP confesses in public that they suffer from PND or they suspect that they might have it. They are *small* in the sense of Georgakopoulou (2008) in that they are short fragments recalling recent events and ongoing ones and thus depart largely from a full-fledged confession.

In the Western tradition, confessions are linked with a Christian religious practice and are commonly seen as a type of disclosure in which one reveals sins or some kind of wrongdoing, for which some form of punishment or absolution is received to 'repair' the soul. Because confessions are linked with authority (priest, judge, physician) who has the right to impose a judgment, scholars such as Foucault (1990) critique confessions as a product of repressive power and a tool of disciplining (Jones 2016). In her extensive study of the history of confession, Taylor (2008) observes that modern day confessions are not necessarily speech acts through which one admits what one has done wrong, but rather express "a desire to tell another who one is" (Taylor 2008: 250) and this telling can be a source of liberation, empowerment, healing and change (Jones 2016).

The confessions studied here belong to this type of modern day confessions in that they involve a revelation of something which is not wrong, but has been kept secret because of feared social sanctions. At the same time, the choice of lexis used in the small confessions evoke the big canonical narrative grounded in the religious practice of confessing and based on the self-revelation as a sinner (Foucault 2003: 163).

A1 is an illustrative example of this kind of small confession with the *big* narrative being evoked through the use of 'admitted' (see Extract 1). When used in the first person and in the active voice, the verb 'admit' suggests an act of confessing something wrong or unpleasant as in the beginning of the canonical religious confession 'Father, I have sinned'. By using the verb 'admit', A1 self-positions as a confessing subject. Alongside the use of verbs such as 'admit', the confessional character of these small stories and the position of confessing subject are evoked through direct references to PND as a secret. A8 does it explicitly when she says "been hiding PND for months" (see Extract 2).

Extract 1

A1: Have finally admitted i have pnd. I've had depression before so i know i have a slow road to recovery ahead. I would so appreciate anyone else's stories of how they overcame pnd …

Extract 2

A8: My baby is 8m old, been hiding PND for months, mainly because I was embarrassed and worried what people would think. This was very stupid. Last week I had a nervous breakdown …

Self-positioning as a confessing subject can stem from the sense of isolation and signals inferior status in society (Jones 2016). In the confessions studied here, this is often indexed through references to the difficulties in telling about the experience. In Extract 3, A17 starts hesitantly with "I don't quite know where to start", while in Extract 4 A2 admits that she is embarrassed to disclose her true feelings. This small confession is a paramount example showing how the 'untellability' of PND puts women in isolation and turns them to a voice with no listeners (cf. Plummer 1995).

Extract 3

A17: I don't quite know where to start. I am a mother of three with a baby of 5 months, so life is pretty stressful at the moment but up until now i feel i've been coping fine but for the past couple of weeks all i seem to be doing is crying …

Extract 4

A2: I have been feeling like I have postnatal depression for a couple of months now. It's only getting worse but I can't manage to tell anyone. I tried to talk to a health visitor but was scared to say how I really felt so she just said I was fine. I don't know how to tell someone how I'm feeling. I feel so embarrassed.

The most frequent way of signalling the inferior status is through the projection of epistemic self (Schiffrin 1996) that negatively self evaluates. Negative self-evaluations occur prominently in expressions of feelings and in self attributions. For example, A4 self-describes as a "total failure" and "a weepy nervous wreck", while A18 labels herself a "mess". The negative self-evaluation is almost always used when the identity of the mother is foregrounded. For example, A2 admits: "I often think I am a terrible mother", whereas A5 describes herself as "a rubbish mother" and A11 compares herself to "a crap mum". At the micro-level, the constant negative self-attributions evoke a sinner position so typical of the canonical religious confession and are a kind of verbal self-flagellation. At the macro-level, this position shows the internalisation and thus the power of the normative model of intensive mothering (Hays 1998), which sets joyful, active and selfless mother as the norm of 'good'

motherhood, against which feelings outside this frame are evaluated as not normal and hence bad.

The confessional character of these stories is also evoked through the disclosure of ambivalent and negative feelings towards newborns – essentially a 'sin' when evaluated against the hegemonic model of intensive mothering (Hays 1998). A9 admits that she felt nothing towards her new born baby ("Once DS <dear son> was born, I felt nothing, absolutely nothing, towards him") and A1 confesses that she wanted to give her newborn daughter up for adoption ("I just looked at her and said that I wanted to put her up for adoption. I meant it. I had no connection"). A2 reports hate and "seething with resentment" at her newborn son and A12 records feeling pleased to leave her daughter "and go to the shop" and not wanting "to go back".

Such stories can clearly be positioned in a direct opposition to the hegemonic discourse of intensive mothering (Hays 1998). Disclosure of negative feelings towards a new born child is risky because it could meet with societal sanctions including criminalisation. However, such feelings are not unusual. The experience of giving birth and looking after a new born baby is a huge physical and emotional challenge with many moments of frustrations and anxieties. The intensive mothering ideal (Hays 1998) idealises the subject position of a happy and selfless mother and silences other feelings rendering them 'untellable'. In openly admitting negative or ambivalent emotions towards a new born child, the women in the forum disrupt this hegemonic model and create digital spaces for alternative versions of motherhood.

The kind of modern confessions studied here serves therefore a double function. Although they enforce a positioning of a sinner, which the mothers evidently take up in the form of negative self-evaluations, the act of confessing allows them to verbalise the hidden experience of motherhood. In so doing, it enables a transformation from a subject without a voice to an agentive one who is courageous enough to tell a story of motherhood which is not compatible with the model of intensive mothering (Hays 1998). In this sense, the confession is an act of resistance. But it could be used strategically too. Disclosing negative and ambivalent feelings around motherhood can meet with public condemnation and be sanctioned. Orton-Johnson (2017) has shown that mummy bloggers who 'boast' about maternal deficiencies are likely to be publicly condemned. Starting from the *mea culpa* position can, in some ways, 'protect' the confessing subject from a too strong judgment of the audience and shift the focus onto strategies of 'soul' repair. The confessional character of these stories invites the readers to be less of a jury and more of a confidant (cf. Jones 2016).

The next section examines the ways in which the audience of mumsnetters responded to the small confessions.

4.2 Response stories: exempla

The initial confessions triggered waves of response stories mostly in the form of exempla. Similar to the confession, the exemplum is a canonical narrative genre with roots in ancient rhetoric (Lyons 2014). It belongs to the group of moralising genres whose main function is to prove a moral point (Martin and Plum 1997). The structure of an exemplum is similar to that of the canonical narrative and involves orientation, tellable event (incident), interpretation and coda; the difference is that the teller will select an incident with the view not to stress its unusualness, but to articulate and share a judgment (Martin and Plum 1997). Extract 5 illustrates the many features of exempla identified in the studied contexts.

Extract 5
B1: I had PND with DS <dear son>. It hit me like a brick wall. I was supposed to love him, not hate him. I was supposed to leap to him at every whimper brimming with maternal instinct, rather than pulling the duvet over my head. I don't have time to post as much as I'd like as I have to get away to pick the beautiful, wonderful, amazing little guy up from nursery. But it gets better. Every day the fog lifts a tiny bit and eventually it all fades into insgnificance.

Most of the exempla involve a short orientation, in which the respondents state that they had or are having PND. In this way, the teller articulates a shared experience, which creates a bond between the OP (now listener/reader) and the teller. It is this identification with the listener/reader which is at heart of the exemplum making the response story relevant to the listener (Jones 2016). This identification is further reinforced through taking up the difficult theme of negative emotions surrounding motherhood ad disclosed by the OP. In the studied exempla we find admissions of a lack of maternal instinct (B1: "I was supposed to leap to him at every whimper brimming with maternal instinct, rather than pulling the duvet over my head"), lack of bonding with the child (D2: "I really wasn't bonding with DS <dear son>"), suicidal thoughts and attempts (L1: "It came to a head when I held a knife to my wrist", F9 "Sometimes, I'm so tormented, I feel like throwing myself under a bus"), giving up on motherhood (E4: "I told my husband he should leave me and take our DS with him as they both deserved so much better"), self-harming, starving and binge-eating (B5: "I self-harmed, starved and binge-ate", C14: "My binge eating returned during maternity leave"). In disclosing experiences that do not square well with the intensive mothering ideal (Hays

1998), the respondents re-voice the message of the OP and in doing so create a sense of solidarity and shared understanding. This helps validate and 'normalise' the turbulent PND experience of the OP (see section 4.3).

Similar to the stories analysed by Jones (2016), the identification with the listener/reader is also re-emphasised in the coda, which often contains expressions of reassurance through the repetition of the evaluative phrase 'it gets better' and its many variations mostly in the future tense ('it will get better). For example, in the thread initiated by A1, 16 out of 24 exempla include this phrase with 'will' being often capitalised ('it WILL get better). 'Will' is an example of a semi-modal auxiliary often used for the purpose of prediction without involving human agency (Biber et al. 1999). In contrast to other modals and semi-modals, it involves a higher degree of certainty. The use and an extra emphasis on 'will' in the phrase orientates the reader to the future and gives her some certainty that things will turn for the better without putting too much stress on personal agency. The phrase also reinforces the bond with the teller in that it develops trust and gives reassurance. It is the knowledgeable teller who speaks from experience which, in turn, gives the statement credentials (I know it will get better). This is a good example of a lexical manifestation of the position that the genre of exemplum makes available. Using an exemplum gives the teller not just a specific structure to tell a story, but it allows her to pursue a didactic intent in that she can interpret the meaning of the story for the listener/reader. As Jones (2016: 327) states, "claiming the right to produce an exemplum involves claiming a broader social identity, that of a 'teacher' or 'mentor', and of positioning listeners in the role of 'students' or 'disciples'". In this way, the exemplum has a didactic purpose; it is a tool of knowledge creation and dissemination (Toolan 1988).

In the studied exempla, the position of the knower is assumed not only through asserting the similar experience, but also in the ways in which women talk about PND as a medical condition. In fact, one of the key features of exempla used in the studied sample are references to knowledge about PND and what to do about it. In this way, respondents display lay experiential knowledge or *lay expertise* about medical matters that they acquired as a patient (Sarangi 2001). While some scholars are sceptical about this kind of knowledge and question its status as expertise (e.g. Prior 2003), research concerned with health online forums suggest that it is precisely this kind of lay expertise which is appreciated by forum users and has empowering effects on them (Anesa and Fage-Butler 2015).

Lay expertise is articulated in the exempla studied here in many ways. First, it comes into the view in the ways in which PND on the forum is conceptualised as an illness within the

body, which can be treated (C15: "This is an illness that can be treated, there will be an end", F4: "I have an illness which needs treatment like any other"). We also find here frequent assertions of PND being caused by hormonal imbalances in the brain. For example, G6 asserts that "you are ill because your brain isn't functioning properly", while H9 claims that "there is a chemical imbalance that needs adjusted … it's a horrible illness caused by hormonal /chemical imbalances that you have". In a similar vein, F2 asserts to A2 that "You are NOT a terrible mother! Thats the pnd talking" and D4 stresses that "It's not you, it's a horrible combo of circumstances and hormones. Evil, evil hormones". In most of these examples, PND is described as a biological entity to which something can be done (treatment). This comes into view in the way in which PND is syntactically positioned as a grammatical object or a predicative. This echoes the way in which the medical profession generally approaches illness as a manageable object to be labelled, described, diagnosed and treated (Fleischman 1999). The 'objective' way of looking at illness is further emphasised by the types of sentences and linguistic resources used therein. Most of the displays of lay expertise are declarative statements without any modal elements, which emphasises their factuality and truth. By using this kind of statements the teller claims not just expertise; she also projects to the listener certainty and help her distance herself from the condition. This is emphasised by the use of the personal pronoun 'you', which directly addresses the OP. In this sense, some of the participants in the forum fulfil the professional role normally expected of a medical practitioner which involves "the demonstration of what is known (i.e., certain)" (Sarangi and Clarke 2010: 142)`.

This seems to be much needed as it fills the limbo in which women with PND find themselves also after consulting medical practitioners, who tend to be on the side of caution. A good example of the need for certainty is the thread started by A2, who suffers from PND and discloses her reluctance to take prescribed ADs because she breastfeeds (see Extract 6):

Extract 6

A2: I have been diagnosed with PND and have been prescribed anti depressants (Sertraline). I am breastfeeding and the doctor couldn't assure me the drugs would be absolutely safe - only that the 'benefits outweigh the risks'. She also told me to watch out for any strange behaviour in my baby. I am trying to get better without them but am finding it a struggle. I often think I am a terrible mother and that my children might even be better off without me… AIBU to not take the drugs?

The issue of taking ADs while breastfeeding is controversial not least because the effects of ADs on breastfed infants are not fully understood. Thus, for breastfeeding mothers ADs

are generally not recommended and in mild PND cases the first line of treatment normally involves non-pharmaceutical solutions (NHS 2016). In moderate and severe cases, ADs are prescribed but research suggests that compliance rates for breastfeeding mothers are low. One of the reasons is that breastfeeding has become a firm principle of intensive mothering (Hays 1998) raising to the status of moral responsibility intensely promoted by health professionals and parenting experts (Lupton 2011, Faircloth 2010, Lee 2008). Breastfeeding has some benefits, but it might not be the right option for every mother. Also, scientific evidence for health benefits of breastfeeding is not so clear cut and more research is needed to demonstrate exact causality (Lee 2011). Yet, the intensive mothering ideology equates 'good' mother with breastfeeding mother and alternative choices are interpreted as irresponsible.

Against this background of risks and moral responsibility, it is not surprising to see that A2 defines the problem as a moral dilemma (Am I being unreasonable?). The OP also clearly shows that the decision to take ADs is not just a matter of swallowing pills, but it is intimately tied with the regime of intensive mothering. A2 self-positions as a 'terrible mother' and in order to restore some kind of 'good' motherhood, she decides not to take ADs and to carry on with breastfeeding. This is a good example illustrating the pervasiveness of the moral creed of breastfeeding as a measure of 'good' motherhood (Kukla 2009).

The medical expertise does not give the OP reassurance and hence she has turned to the audience of mumsnetters for opinions. Within a few minutes, she receives responses mostly in form of exempla. The respondents share their knowledge and experience about the use of ADs in breastfeeding and do so mostly by drawing on the voice of biomedicine including the biomedical terminology (names and acronyms of ADs) and dosage. Extract 7 and 8 are illustrative examples of this kind of responses:

Extract 7

I had it <PND> after all of mine and it was particularly bad after my 3rd. I had been on Prozac, but was taken off it towards the end of my pregnancy because it is known to have effects on breast fed babies. I then nosed dived when DS was 6 weeks old, and was started on sertraline, which is considered safer for breast feeding. I carried on feeding him till he was over a year old, and didn't have any problems with it at all. I just realised that if I didn't take the medication I couldn't function, and couldn't care for my children properly so for me, medication was the best thing. I hope this helps, and I hope you feel better soon.

Extract 8

Another here who has PND and is breastfeeding. My DD is 11 months, I have been on Sertraline 100mg for over 6 months now and exclusively BF. My daughter is tremendously healthy. Maintaining the breastfeeding relationship has, in conjunction with careful medication, really helped me over the worst of postnatal depression. It is an awful illness … Good luck and I hope you find your way to feeling better soon.

The extracts above show clearly the role of exempla as didactic tools. A section of an experience was selected to prove the point that taking a particular AD while breastfeeding is safe. The certainty is established through reporting on transformative effects of taking ADs and no visible effects on children. The credibility is further assured by references to medical literature and personal research (Y2: "I had to take ads whilst breastfeeding, the percentage that passes through milk is tiny, we looked into it", D2: "I researched it and spoke to others in my situation before I made the decision", M2: "I did a LOT of research on how to manage my anxiety"). In this way, the respondents come across as well informed and credible individuals supplying reliable personal knowledge validated through experience. There is still a great deal of scepticism surrounding the exchange of medical information by lay people online with some scholar pointing to an unreflective use of this knowledge with potentially negative consequences for patients and doctors (see Ziebland 2012 for an overview). This does not apply to the threads studied here; the exempla analysed show a reflective approach to medical information with the tellers showing a critical and exploratory stance when navigating medical knowledge. Similar to online discussions about pregnancy investigated by Hanell (2017), this kind of lay biomedical knowledge is evoked not just to emphasise the position of the knower but to create an experiential knowledge resource that could help others make an informed decision. How OPs take up the messages and what effects they have on them is shown in the next section.

4.3 Transformations and redefinitions

The OPs respond to exempla throughout the threads predominantly with thank-you messages. At the end in the last post they often position themselves towards the conversations thus offering some insights into the effects that the exchanges had on them. For example, stories about the use of ADs prompted A2 to reflect on her position and helped her take action. The worried epistemic self signalled in the initial post (see Extract 6) has turned into an agentive self who acts ('I have just started counselling').

Extract 9

A2: All the posts have given me lots of food for thought. I still haven't made my mind up, but I do feel reassured knowing others have taken the medication and BF. I have just started counselling, and am trying everything I can to feel better.

The same happens to A6. In her confessional post, she self-positions as an embarrassed person afraid to disclose her feelings (A6: "I don't know how to tell someone how I'm feeling. I feel so embarrassed."). In her final post, she reports on a visit to a GP and that she talked to her husband, which brought a relief. She thanks the forum users for their encouragement to do so (Extract 10).

Extract 10

A6: Thanks for all your help. I have been to the gp who was really nice and am now on antidepressants. I have also told dh <dear husband> now so I'm feeling relieved Thanks for everyone who posted I couldn't have done it without you.

C6: I hope you are feeling better. There is always support here.

B6: Well done OP. Hope you keep on feeling better

The participants in the conversations do not only encourage the OPs to take action, they also provide immediate feedback. In Extract 10, B6 praises A6 for taking the recommended action, while C6 offers further reassurance. In many instances, the participants prompt the OP to provide updates, especially if they 'vanished' for a while. Extract 11 is indicative of such prompting. B8 seems concerned with A8's silence and checks how she is. In response, A8 recounts her activities and feelings as she goes through the day.

Extract 11

B8: How are you today A8?

A8 (next day): Don't panic! I am still here.....just. Sorry to vanish for a few days but have been very up and down to put it mildly. Good day today. Even tho DS <dear son> woke at 4am for a feed, I managed to get decentish sleep. DP <dear partner> gone by 7am so got DS up myself, fed him with banana porridge, got him and myself dressed! Trust me that's a miracle!

Monitoring and feedback offered by the participants, updates and thank you notes from the OPs are all important conversational mechanisms of relational work in this online community. While the exempla provide the OPs with stories from which they can learn, the feedback and monitoring establishes a sense of community and togetherness. This all assists the OPs in redefining the situation and repair the 'spoiled' identity even if temporary. It prompts them to take action that they were otherwise reluctant to do and help them gradually establish some kind of normality in the otherwise emotionally turbulent life.

5. Conclusions

The starting point for this study was the observation that online peer-to-peer health communication have transformative and empowering effects on patients but little is known about the processes and practices that make such transformations possible. Studying online stories and interactions about PND as they unfold, this paper sheds light on narrative practices that help achieve these effects. The analysis points to the prominence of two narrative practices that form the 'building blocks' of interactions about this stigmatised condition that of *small confession* and *exemplum*. *Small confessions* act as 'openers' letting into the public space the hidden experience of PND. Although the confession positions the OP as an inferior subject and a 'sinner' - a position which the women take up through the negative self-evaluations and attributions, I argued that in the same act of confessing they exercise an agentive role. This narrative practice enables them to tell the 'untellable' and voice emotions that lay clearly outside the ideal of intensive mothering (Hays 1998). By disclosing such emotions and feelings, they resist this ideology and carve out digital spaces in which alternative discourses can be voiced and shared. This triggers immediate responses in form of chains of exempla. The use of the exemplum allows the teller to speak from the position of a knower and to create a story with a didactical intent. The position of the knower is signalled through references to the shared experience of PND and through taking up the voice of biomedicine often in factual statements. But in contrast to biomedical accounts from a medical textbook, this knowledge is filtered and validated through personal experience, which gives it a sense of authenticity and credibility. In this way, the respondents help validate the experience of PND and create an experiential knowledge resource which readers can take up, reflect on and use to potentially transform themselves. Indeed, some empowering effects are documented in the last responses by the OPs. The initial negative epistemic self expressed through the self-positioning as a 'bad' and not-functioning mother is in the course of online interactions gradually transformed to an agentive self; the OPs narratively recount ongoing activities and take actions, for example, see a GP, tell the partner or explore different treatment options. In this way, online story telling and sharing has therapeutic effects confined not just to the virtual context; it contributes to real transformations in the offline world.

A question arises to what extent the digital in general and Mumsnet in particular afford telling and sharing stories of 'untellable' issues? The anonymity of the digital medium creates a safe space in which participants feel free to share personal and intimate details of their life.

The participatory nature and the opportunity of immediate response that the discussion forum affords is another technosocial feature (Ley 2007) which facilitate telling and sharing trouble stories. After all, we tell stories not just for ourselves but to exchange and engage with a listener. Moreover, Mumsnet with its fairly open talk guidelines and little intervention may further encourage people to share their stories. For example, Mumsnet allows for the use of swearwords and prohibits only contents that would otherwise be punishable by law including racist, sexist, homophobic or obscene language.

While the technosocial features play an important role in facilitating trouble telling online, it is the generic narrative resource which the posters use that enables therapeutic and transformative effects. Similar to the personal stories of gay-bullying analysed by Jones (2016), the tellers here appropriate the big narratives to claim 'textual authority' in order to talk about experiences that lie outside the social boundaries. In doing so, they challenge the hegemonic models that set these boundaries and create a knowledge resource that others can use to verbalise the 'untellable' and navigate the medical system. In this way, these online stories of PND form digital bodies of texts (Van Doorn 2011) that articulate the 'untellable' and work to transfer these articulations into offline actions. While the resources contributed to transformations of individual participants in the forum, given the popularity of Mumsnet as the most consulted parenting website in the UK we can reasonably expect that the reach can be much wider.

This study enhances our understanding of digital practices in online peer-to-peer communication in the context of a stigmatised mental health condition. It shows the importance of the interplay between technosocial factors and narrative resources that together enable and facilitate transformative and therapeutic effects of online interactions. The findings from this study make contributions to online health communication and can be of relevance to the sociology of parenting and maternity with implications for public policy around support for maternal mental health.

Nevertheless, there are three important caveats that need to be considered when interpreting the results. First, any piece of research that uses Mumsnet data needs to take into account its membership. As a Mumsnet (2009) census showed, most of the members are well educated middle-class women aged 30 to 40 from London and the South-East of England, many of whom are professional working mothers and readers of the left-leaning national newspaper *The Guardian*. Pedersen (2016) has shown that most mumsntters endorse feminist ideals of equal opportunities. Their social positioning might simply give them a greater

latitude to engage critically with the discourse of intensive mothering and contest it because they are already in a space in which such contestations are less risky (cf. McKenzie-Mohr and Lafrance 2014). Also, the fact that they use the elaborate genre of exemplum and engage in complex ways with biomedical knowledge could be a result of high literacy skills that they have at their disposal. Further research would need to examine digital spaces that include more diverse memberships.

Secondly, although the overall message might appear positive, we must not forget that the position from which the women begin to speak is that of mental illness. This suggests that the resistance to the hegemonic models such as that of intensive mothering (Hays 1998) could outside this digital community be considered a kind of pathology minimising the potential for social change. Although by no means is this research concerned with diagnostic aspects of PND, it nevertheless shows how firmly this condition is tied to the moral orders of how to 'do' motherhood in contemporary society thus making them a big part of the problem.

Finally, the results presented in this study are based on a small sample of online conversations conducted within a very particular setting and hence cannot be generalised beyond this context. I tentatively suggested that the pattern of narrative structure (confession followed by exempla) might be a feature of trouble telling and sharing online but future research needs to verify it by exploring other contexts of digital peer-to-peer communication.

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Appendix A: Classification of posts into narrative structures

1.	**A1 16:41:08**	**Initial Confession**
2.	**A1 16:45:54**	**Question**
3.	B1 16:48:57	Response Story 1: Exemplum
4.	C1 16:51:11	Praise - Response Story 2: Exemplum
5.	**A1 16:52:14**	**Thanks**
6.	**A1 16:55:18**	**Recount**
7.	D1 16:55:57	Response Story 3: Exemplum
8.	**A1 16:56:38**	**Recount**
9.	E1 16:57:03	Response Story 4: Exemplum
10.	F1 16:57:53	Empathy - Response Story 5: Exemplum
11.	G1 16:59:28	Response Story 6: Exemplum
12.	**A1 17:00:13**	**Thanks**
13.	**A1 17:02:32**	**Recount**
14.	H1 17:04:13	Response Story 7: Exemplum
15.	**A1 17:06:34**	**Question**
16.	**A1 17:20:53**	**Recount**
17.	I1 17:21:18	Response Story 8: Exemplum
18.	**A1 17:23:27**	**Thanks**
19.	J1 17:51:50	Response Story 9: Exemplum
20.	K1 17:57:32	Response Story 10: Exemplum
21.	L1 17:58:41	Response Story 11: Exemplum
22.	M1 18:00:33	Response Story 12: Exemplum
23.	N1 18:09:45	Response Story 13: Exemplum
24.	O1 18:14:53	Response Story 14: Exemplum
25.	P1 18:22:22	Response Story 15: Exemplum
26.	**A1 18:24:32**	**Thanks**

27.	Q1 20:40:19	Response Story 16: Exemplum
28.	R1 20:50:28	Response story 17: Exemplum
29.	Q1 20:55:25	Response Story 18: Exemplum
30.	S1 22:50:29	Response Story 19: Exemplum
31.	T1 22:54:57	Response story 20: Exemplum
32.	U1 22:58:49	Response story 21: Exemplum
33.	V1 22:59:24	Response story 22: Exemplum
34.	U1 22:59:56	Advice
35.	W1 23:20:59	Response story 23: Recount
36.	X1 23:42:03	Response story 24: Recount
37.	Y1 23:46:40	Response story 25: Exemplum
38.	Z1 00:17:52	Response story 26: Exemplum
39.	Z1 00:21:53 (next day)	Advice
40.	**A1 07:54:03**	**Thanks - Recount**
41.	**A1 09:02:33**	**Recount**
42.	**A1 09:07:25**	**Recount**
43.	N1 09:15:57	Response story 27: Exemplum
44.	Y1 13:07:43	Response story 28: Exemplum

Bio-note

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